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	17E038	A. BUILDING _____ B. WING _____	C 05/06/2013

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HAVILAND CARE CENTER LLC	200 MAIN HAVILAND, KS 67059

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F 000	INITIAL COMMENTS The following citation represents the findings of the complaint survey for complaints #64821 and #65385.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 48 residents with 2 residents sampled for leaving the facility without staff being aware, with 1 of the 2 residents having impaired cognition. Based on observation, interview and record review the facility, failed to provide adequate supervision and failed to develop and implement a system in which the staff would be able to effectively identify and monitor residents who had changes in delusions or behaviors that put the resident at increased risk of leaving the facility. (#1 and #2) Findings included: - Review of resident #1's signed physician's orders dated 3-1-13 revealed diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception, and emotional reaction)	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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and extrapyramidal disease (movement disorders as a result of taking certain medications).

Review of the annual MDS (Minimum Data Set 3.0, a required assessment) dated 11-17-12 revealed a BIMS (Brief Interview for Mental Status) score of 12 indicating moderate cognitive impairment. It revealed the resident had difficulty focusing, disorganized thinking behaviors that fluctuated, and psychomotor retardation (sluggishness, staring into space, moving slowly). It also revealed the resident had hallucinations, physical behaviors such as hitting self, scratching self, smearing feces, rummaging, throwing/ smearing food, and disruptive sounds which occurred daily. The MDS indicated the behaviors significantly interfered with the residents ability to participate in activities or social interactions, intruded on other residents privacy, and disrupted care and living environment. The resident rejected care 1-3 days out of the past 7 days. It also revealed the resident received antipsychotic and hypnotic medications 7/7 days during the assessment period.

Review of the quarterly MDS dated 2-13-13 revealed a BIMS score of 12 (moderate cognitive impairment). The MDS indicated the resident had fluctuation problems with inattention and disorganized thinking and had psychomotor retardation. It also indicated the resident had hallucinations and behavioral symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, or screaming and disruptive sounds daily. The resident rejected care 1-3 out of 7 days during the assessment period. It also indicated the resident received antipsychotic and

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hypnotic medications 7/7 days during the assessment period.

Review of the Cognitive Loss / Dementia CAA (Care Area Assessment) dated 12-4-12 revealed the resident had moderately impaired cognition. The resident was alert and oriented to facility and daily routine. The resident had no known neurological factors to cause cognitive loss and had potential for cognitive decline due to psychotropic drug side effects. The resident continued to talk to hallucinations, was up during the night for short periods of time with no noted aggression.

Review of the Behavioral Symptoms CAA dated 12-4-12 revealed the resident often refused care or sleeping medications due to hallucinations. The resident had a long history of schizophrenia, disorganized type presenting with hallucinations and talking to self/ hallucinations often. The resident was on long-term medication regimen to control Schizophrenia with no noted side effects from medications that caused behavioral symptoms.

Review of the Psychotropic CAA dated 12-4-12 revealed the resident had long standing mental illness of schizophrenia with long term medication therapy of antipsychotic medications to effectively control disorder.

Review of the elopement risk assessment comments dated 2-8-13 indicated the resident had made no verbalization or attempt to leave facility and continued without safety decision issues. Continue with no off ground privileges

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and 2 hour visual checks.

Review of the elopement risk assessment dated 4-22-13 revealed a score of 9, moderate risk for elopement. The assessment indicated the resident had never refused psychotropic medications but had a comment written "resident with refusal of Ambien (sleep medications) often sleeps throughout day often, easily redirectible". Other comments included the resident left facility grounds stating "just went for a walk" had a heavy coat and 3 shirts with him/her. The resident returned on his/her own and a wander guard (type of personal alarm) was placed to left ankle. The resident continued with 2 hour visual checks, wander guard functionality checked every shift.

Review of the care plan dated 7-28-2011 with no noted updates prior to leaving the facility without staff awareness revealed a potential for problems regarding no off ground privileges. Interventions included: document in behavior book if resident leaves grounds, educate resident on way to gain off grounds was by following care plan, redirect resident if attempted to leave grounds, and remind resident he/she did not have off ground privileges. The care plan was updated with a handwritten intervention dated 4-22-13 indicating the resident wore a wonder guard to left ankle related to leaving facility. The care plan also had a problem related to potential for injury related to minimal risk for impaired safety decisions revised on 11-23-12 with a goal the resident would not leave facility grounds or attempt to elope over next 90 days. Interventions included to answer call lights promptly, check every 2 hours, educate resident to sign in and out on clipboard if goes

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outdoors, educate resident he/she is not to leave grounds, monitor for changes in mental, emotional, physical conditions. It was updated on 4-22-13 to include a handwritten problem of moderate risk for elopement due to leaving facility grounds with an intervention of the resident wearing a wander guard bracelet to left ankle, check functionality every shift.

Review of the nursing communication sheet dated 4-22-13 sent to physician at 12:15 p.m. revealed "Res(ident) eloped from facility at 0943 this a.m. Res(ident) has not yet returned." " Res(ident) returned at 1305 on his/her own accord" with a physician's response of "OK" .

The nurse's notes dated 4-22-13 at 8 p.m. revealed the resident had hourly checks and wore a wander guard to left ankle. The resident went out the front door one time and the alarm sounded. He/she stood on the front porch and the nurse told the resident staff had to supervise him/her when outside and the resident went back into the facility.

Nurse's notes dated 4-24-13 at 2 p.m. revealed the resident ambulated in the halls and went out the front door and sat in a chair on the porch at 12:10 p.m. and he/she was compliant with request to return indoors.

Review of the Social Service discharge planning assessment dated 2-6-13 revealed the resident still had insomnia issues and safety for risk of elopement.

An observation at 12:06 p.m. on 4-25-13 revealed the resident walked down the south hall

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and stopped in the middle of the hall, mumbling, and making hand gestures and then walked to the south hall door. He/she stood there for about 3 minutes when staff told the resident very politely that he/she needed to get away from the door, or the alarm would sound. The resident then turned around and walked away from the door and toward the north hall.

Observations from 12:58 p.m. to 3:56 p.m. revealed the resident mumbling, words did not make sense. The resident walked up and down the halls, sat in the front TV area, talked to self and made gestures with his/her hands, and then got up and walked in the halls again.

During an interview on 4-25-13 at 3:46 p.m. direct care staff D reported that every resident was checked visually at least every 2 hours. Staff D reported that he/she had learned to watch for increased agitation or other mood/behavior changes and would watch the resident a little closer. He/she reported if the nurse was not in the nurse's station, staff D tried to stay at the station to keep an eye on the front door.

During an interview on 4-19-13 at 2:16 p.m. direct care staff E reported the residents earn off ground privileges according to how they function and participate within the facility. When a new resident came in they did not have off facility grounds privileges for at least 30 days and then it was evaluated again. Residents who had off ground privileges could either have them for about 30 minutes at a time, or only on specific days. The residents were supposed to sign out when and where they went and put down the time they left and came back. Staff did 2 hour checks

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on every resident and if staff did not find someone for that 2 hour check, and it was someone who had off grounds, staff checked the sign out sheet. If the resident signed out properly staff could call or go to that place and see if they were there. Residents that could not go out unless supervised were residents who were not safe smoking and residents who had wander guards.

During an interview on 4-29-13 at 3:12 p.m. direct care staff F reported there was a list of residents at the nurse's station that showed who could and could not go off grounds and for how long. The list also included residents who could not go outside without supervision. Staff F reported residents who went out the front door were supposed to sign out if they were going for a walk or going to sit on the porch. The smokers did not sign in or out when they went to the courtyard because staff were usually out there with them. Residents who had off facility grounds privileges can go to the store by themselves or can go where they want but have to sign where they are going. Staff F reported orientation was about a week to a week and half. He/she reported the hardest part was getting faces put with names but the 2 hour checks helped a lot with that as well as passing out cigarettes and things. Staff F reported the staff couldn't find resident#1 for morning coffee break which is about 9:45 a.m. on 4-22-13, the facility and off grounds were searched and the resident was then seen walking on main street back toward the facility. He/she reported the resident went outside for walks around the building and comes back in.

During an interview on 4-29-13 at 4:23 p.m.

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licensed nurse J reported that residents were supposed to sign date and time when they went out and what they were doing, staff would like for residents who were just going to the porch sign out as well. If a resident had off grounds privileges they could leave facility on particular days for 30 minutes at a time to certain areas in town. The facility got cameras last year to show all the exit doors and that helped a lot in monitoring the residents. When asked about residents who had on grounds privileges that come and go, how staff know the resident will not leave the grounds, or how do they even know who is outside. Staff J confirmed it could happen for someone who was only to be on the facility grounds, to leave grounds without staff knowing they went out or left. Staff would notice them not in the facility or on grounds either at a meal time, coffee break time, or at 2 hour check. "There is a lot of visualization that has to happen here." Staff J reported that normal staffing was 2 aides and a nurse but there are times when it was just one aide and one nurse, staff did what they could. When asked what the system for deciding if a resident was at risk for elopement or if they were safe to be outside some of the time or all of the time he/she reported it was a case by case issue. The nurses could change the frequency of visual checks if needed due to the resident being delusional about wanting to leave. changes in behaviors, more pacing or something like that the resident would be put on 15 minute checks by the charge nurse until the delusion resolved. If the resident had delusions and behaviors that were harmful then the nurse would usually do 1 on 1 (1 resident to 1 staff supervision) during that time and the Administrator and Director of Nursing were notified, as well as the guardian if they have

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one, psychiatrist and the screener. When the delusions are over, if they did not go to a facility for evaluation, the visual check time frames were lengthened until back to the 2 hour checks.

During an interview on 4-29-13 at 5:02 p.m. Administrative nurse I reported the resident had on grounds privileges and would walk around the block and come back into the facility. Staff I reported that he/she never thought the resident would walk off the block because he/she had a specific routine of how he/she did things. Staff I also reported when residents went off the porch, that was when they were to sign out. If someone just went to sit on the porch they do not have to sign out. When asked how staff knew a resident who was only supposed to be on the porch or just on the facility grounds doesn't go off the grounds he/she reported that was why they did checks because they don't know. Staff I reported that the determination of resident at risk for elopement was based upon their history, current and past, elopement assessment which according to it every one in the facility was at least a low risk because of mental hospitalization in the past. If a resident was talking about wanting to get out of here or having that type of delusion regarding leaving staff would start doing different things. He/she reported they usually put the resident on 15 minute checks and then when staff see the resident getting better they were to adjust the check times. If a resident did leave the facility grounds without permission, when the resident returned staff did an assessment. Staff I reported he/she would ask the resident why they left, is someone telling you to leave or go somewhere, and then if that was the case will usually put a wander guard on them but not always. If they

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just went to get a cappuccino the resident may have to go outside with supervision or have 15 minute checks done but not a wander guard.

During an interview on 4-29-13 at 8:18 p.m. Administrative staff C reported that typically staff could view residents go in and out the front door and could view residents walking around on the grounds. Most residents had patterned behaviors and staff kind of knew when a resident was going to be sitting on the porch or sneaking around the corner to smoke a cigarette. When asked specifically regarding how staff knew a resident was high risk of leaving the facility and how they were supposed to monitor the resident Staff C reported the assessment tools, elopement risk assessment, is a base line. Once a change was implemented the floor staff were notified by him/herself and Staff I. They were also the ones who determined if the screener was to be contacted, if 1 on 1 supervision needed implemented, and then there was a reassessment process. Floor staff was required to pay attention to behavior so they could document appropriately in the behavior book. If a resident left the facility grounds he/she was to be placed on 3 day charting by the nurse.

On 5-1-13 at 2:20 p.m. Administrative staff C reported the floor staff reported information to him/herself and Administrative nurse I and then were given directives to change the plan as needed. The treatment team reviews and determines for how long the change will be in effect.

Surveyor asked for a policy on 5-1-13 regarding how direct care staff knew when a resident was at

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high risk for leaving the facility and how they knew to monitor differently to ensure the resident remained safe. T he facility did not provide a policy as of 5-2-13.

The facility failed to develop and implement a system in which the staff would be able to identify and provide adequate supervision to ensure a cognitively impaired resident who was allowed to go outside but had to remain on facility property did not leave property without staff knowledge.

- Review of resident #2's signed physician orders dated 3-1-13 included the diagnosis of schizoaffective disorder unspecified (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception, and emotional reaction).

Review of the admission MDS (Minimum Data Set 3.0, a required assessment) dated 8-16-12 revealed a BIMS (Brief Interview for Mental Status) score of 15, cognitively intact and a score of 7 on the depression scale indicating mild depression. The MDS indicated the resident had no wandering, and the only behavior was the rejection of care 1-3 days out of the past 7. It indicated the resident was independent in all care except needed supervision with bathing. It also revealed the resident received antipsychotic and antidepressant medications 7/7 days during the assessment period.

Review of the quarterly MDS dated 2-11-13 revealed a BIMS score of 14, cognitively intact and a score of 14 on the depression scale indicating moderate depression. It also revealed

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the resident had physical and verbal behaviors towards others 1-3 days out of 7 and refused care 4-6 days per week during the assessment period. The MDS indicated the resident was independent with all cares except set up assistance with bathing. It revealed the resident received antipsychotic and antidepressant medications 7/7 days.

Review of the Cognitive Loss / Dementia CAA (Care Area Assessment) dated 8-16-12 revealed the resident had a diagnosis of schizoaffective disorder depressive type which caused refusal of ADL's (activities of daily living). It indicated the resident had no issues with cognitive loss / dementia.

Review of the Behavioral Symptoms CAA dated 8-16-12 revealed the resident had lived at this facility previously and had displayed violence without being provoked, one second happy and the next hitting someone. It indicated no current issues with aggressive behaviors.

Review of the Psychotropic drug use CAA dated 8-17-12 - revealed potential for problems due to resident received psychotropic medications and had no current behavior concerns.

Review of the fall risk assessment dated 11-8-12 revealed a score of 6 which indicated moderate risk for falls.

Review of the care plan dated 8-17-12 included a potential for coping problems related to no off grounds privileges. Interventions included educating the resident on ways to gain off grounds, notify administrator if resident left facility

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grounds, redirect resident leaving grounds alone, and remind resident that staff take 2 groups daily as weather permits to store on Monday and Friday. The care plan was updated on 3-28-13 to include the resident expressing desire to ride bike due to warmer weather with an intervention the resident may go on bike ride for approximately 20 min 1 time per week and stay within 1 block of facility. It had an intervention that staff discussed riding the bike after letting staff know when to go bike riding.

The care plan dated 8-17-12 also included a potential for injury related to moderate risk for elopement. It included interventions of answering the call light promptly, check, and document every 2 hours, consult psychiatrist as needed, monitor for any mental emotional physical conditions. The care plan was updated on 3-31-13 to include the resident was not to leave the building without staff due to elopement. Interventions update included wander guard placed to wrist and checked every shift by nurse - Resident to be visually checked every 15 min until 4/1/13.

Review of the nurse's notes dated 3-4-13 revealed the resident had been out of facility with family and brought back a bicycle that was taken to his/her room.

The nurse's notes dated 3-16-13 revealed the resident had a bike brought to ride otherwise no documentation regarding the resident riding the bicycle noted prior to 3-26-13.

On 3-26-13 at 5:25 pm the nurse's notes revealed the resident left the facility around 5:25 p.m.

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walked around the back of the facility and got on the bike and rode it. Dietary staff saw the resident on the bike and the nurse had directed care staff D to go get the resident. The notes indicated the resident returned to the facility at 5:38 p.m. and stated, "I just wanted to ride my bike for a while". Staff reminded the resident he/she did not have off ground privileges.

On 3-28-13 at 10 p.m. the nurse documented the resident was agitated throughout the shift, made a call to a friend and stated that helped. Resident had not been observed leaving the facility that shift.

On 3-29-13 at 2:55 a.m. the nurse documented the resident was restless and paced in the hall. The resident asked for a pain pill and went to his/her room.

On 4-1-13 it was documented the resident was not in his/her room at 1:40 a.m. at which time a search of the building was started. Police and administrative staff notified. The resident was returned by police officer at 4:25 a.m. and at 4:40 a.m. wander guard place on residents wrist.

Review of the investigation report revealed the resident went out the front door at 8:55 p.m. on 3-31-13 according to surveillance video. Review of the 2 hour check staff documented on 3-31-13 indicated the resident was in the facility at 10 p.m. The check list for 4-1-13 revealed the staff documented the resident was in the facility at the 12 a.m. check but not at the 2 a.m. check. The report also revealed the resident left the facility through the front door at 8:55 p.m. on 3-31-13 and did not return until returned with police at

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4:25 am on 4-1-13. The investigation revealed the statements from 2 different direct care staff was inaccurate and so was their documentation on the 2 hour check list.

Observation on 4-25-13 at 1:16 p.m. the resident went to the licensed nurse staff B and asked him/her if he/she could go outside to get a pop. Staff B and the resident went to the front door and when the resident went outside the alarm sounded, staff B silenced the alarm and the resident returned with the wander guard alarm again sounding and staff silencing the alarm. Resident returned with a bottle of mountain dew in his/her hand.

An observation on 4-29-13 at 4:14 p.m. the resident stood at the nurse's station waiting to get his/her cigarette. Resident was the last one to get a cigarette and then staff went out the courtyard door with the resident. The wander guard alarm sounded when the resident went out and again when he/she came back in.

During an interview on 4-25-13 at 11:56 a.m. the resident reported the rules here were OK. He/she reported that he/she had a wander guard on, showing the surveyor the bracelet on his/her left wrist. The resident reported that he/she had it on so that an alarm goes off if he/she goes outside without staff. The resident reported that he/she was not supposed to go outside without someone that staff approve. When asked if he/she could go out in the smoking area unsupervised the resident said no that he/she still needed someone to go with him/her.

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During an interview on 4-25-13 at 3:46 p.m. direct care staff D reported that every resident was checked visually at least every 2 hours. Staff D reported that he/she had learned to watch for increased agitation or other mood/behavior changes and would watch the resident a little closer. He/she reported if the nurse was not in the nurse's station, staff D tried to stay at the station to keep an eye on the front door. Staff D also reported it was OK for the resident to be outside on the facility property and confirmed the resident had a bike at the facility. He/she reported staff gave the resident medications before the first shift meal and then when he/she did not show the nurse said his/her bike was gone so staff D went to the front door and saw the resident crossing main street heading east. Staff D then got into his/her care and followed the resident and encouraged him/her to return to the facility. Staff D reported the resident got about 4 blocks away from the facility.

During an interview on 4-29-13 at 2:19 p.m. direct care staff E reported his/her understanding was the resident had gone on a home visit with someone and returned with the bike. When the department head staff found out about it there were arrangements made for the bike to be locked and for the resident and staff to have a key and he could only ride it at approved times.

During an interview on 4-29-13 at 4:21 p.m. direct care staff H reported there was a list of residents who had different privileges and some who had bands on that could not go outside or an alarm would sound. When asked how staff knew when someone who could go outside on the premises stays on the premises or leave staff H

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stated he/she "assumed they (residents) were on the honor system".

During an interview on 4-29-13 at 4:23 p.m. licensed nurse J reported that residents were supposed to sign date and time when they went out and what they were doing, staff would like for residents who were just going to the porch sign out as well. If a resident had off grounds privileges they could leave the facility on particular days for 30 minutes at a time to certain areas in town. The facility got cameras last year to show all the exit doors and that helped a lot in monitoring the residents. When asked about residents who had on grounds privileges that come and go, how staff know the resident will not leave the grounds, or how do they even know who is outside. Staff J confirmed it could happen for someone who was only to be on the facility grounds to leave grounds without staff knowing they went out or left. Staff would notice them not in the facility or on grounds either at a meal time, coffee break time, or at 2 hour check. "There is a lot of visualization that has to happen here." Staff J reported that normal staffing was 2 aides and a nurse but there are times when it was just one aide and one nurse, staff did what they could. When asked what the system for deciding if a resident was at risk for elopement or if they were safe to be outside some of the time or all of the time he/she reported it was a case by case issue. The nurses could change the frequency of visual checks if needed due to the resident being delusional about wanting to leave. changes in behaviors, more pacing or something like that the resident would be put on 15 minute checks by the charge nurse until the delusion resolved. If the resident had delusions and behaviors that were

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harmful then the nurse would usually do 1 on 1 (1 resident to 1 staff supervision) during that time and the Administrator and Director of Nursing were notified, as well as the guardian if they had one, psychiatrist and the screener. When the delusions are over, if they did not go to a facility for evaluation, the visual check time frames were lengthened until back to the 2 hour checks.

During an interview on 4-29-13 at 5:02 p.m. Administrative nursing staff I reported that the determination of resident at risk for elopement was based upon their history, current and past, elopement assessment which according to it every one in the facility was at least a low risk because of mental hospitalization in the past. If a resident was talking about wanting to get of here or having that type of delusion regarding leaving staff would start doing different things. He/she reported they usually put the resident on 15 minute checks and then when staff see the resident getting better they were to adjust the check times. If a resident did leave the facility grounds without permission, when the resident returned staff did an assessment. Staff I reported he/she would ask the resident why they left, is someone telling you to leave or go somewhere, and then if that was the case will usually put a wander guard on them but not always. If they just went to get a cappuccino the resident may have to go outside with supervision or have 15 minute checks done but not a wander guard.

During an interview on 4-29-13 at 5:18 p.m. Administrative staff C reported that typically staff could view residents go in and out the front door and could view residents walking around on the grounds. Most residents had patterned behaviors

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and staff kind of knew when a resident was going to be sitting on the porch or sneaking around the corner to smoke a cigarette. When asked specifically regarding how staff knew a resident was high risk of leaving the facility and how they were supposed to monitor the resident Staff C reported the assessment tools, elopement risk assessment, is a base line. Once a change was implemented the floor staff were notified by him/herself and Staff I. They also were the ones who determined if the screener was to be contacted, if 1 on 1 supervision needed implemented, and then there was a reassessment process. Floor staff was required to pay attention to behavior so they could document appropriately in the behavior book. If a resident left the facility grounds he/she was to be placed on 3 day charting by the nurse.

On 5-1-13 at 2:20 p.m. Administrative staff C reported the floor staff reported information to him/herself and Administrative nurse I and then were given directives to change the plan as needed. The treatment team reviewed and determined for how long the change would be in effect.

On 5-1-13 the surveyor asked for a policy regarding how direct care staff knew when a resident was at high risk for leaving the facility and how they knew to monitor differently to ensure the resident remained safe. The facility did not provide a policy as of 5-2-13.
The facility failed to develop and implement a system in which the staff identified and monitored effectively residents who had changes in delusions or behaviors that put the resident at increased risk of leaving the facility for a resident

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